Selection of a Functional Assessment Tool, for the Children's Mental Health Bureau

The Children's Mental Health Bureau (CMHB) has selected the Child and Adolescent Needs and Strengths (CANS) functional assessment tool. The Bureau will continue engaging stakeholders throughout statewide implementation.

THE SELECTION PROCESS

The workgroup process engaged many stakeholders, including Montana providers, developers of the instruments, and users of the instruments in other states, along with an extensive investigation conducted by Bureau staff.

❖ **September 13, 2011**- providers and agency representatives were presented with information about two functional assessment tools by Magellan Medicaid Administration: the Child and Adolescent Needs and Strengths (**CANS**) and the Child and Adolescent Service Intensity Instrument (**CASII**).

❖ **September 26, 2011** – E-mail sent to providers asking for input in establishing criteria to use in choosing the ideal functional assessment tool.

❖ **October 13, 2011** - Provider meeting / phone conference call in Helena.

❖ **September, October, November, 2011**: Internet research and environmental scan by Bureau staff:

- Phone and e-mail contact with Dr Bob Klaehn, one of the developers of the CASII. Dr Klaehn came to Montana to train providers in the CASII during the implementation of the PRTF Waiver.

- Phone and e-mail contact with Dr John Lyons, one of the developers of the CANS. Dr Lyons is available for ongoing consultation and customizing of the instrument for Montana.

- Other states were contacted directly regarding their implementation of either the CANS or CASII, including: Minnesota, Arizona, Oregon, and Maryland. Other states' websites reviewed included Massachusetts, New Jersey, Virginia, Indiana, and Illinois.

- Three Montana providers – all CASII-trained - took CANS online training and provided feedback to the Bureau.

❖ **December 1, 2011** - Workgroup selected the functional assessment tool.

ABOUT THE CANS

The CANS is a strengths-based Total Clinical Outcomes Management (TCOM) system that preserves emphasis on serving youth and family. It was developed by Dr. John Lyons, University of Ottawa. www.praedfoundation.org. It is also a quality management tool and can measure accountability at the provider and system level. The web-based software application will enable CMHB to build a statewide database for collecting, storing and monitoring performance and outcome data for use in reporting to state legislators, federal granting agencies, providers, youth and their families, as well as for internal reporting and program monitoring.

Additionally:
- The instrument is completed by teams, emphasizing family voice and choice.
- It links the assessment process to individualized service plans.
- It is research-based with established inter-rater reliability.
- It is compatible with High-Fidelity Wraparound facilitation and family-driven planning.
- Several integrated CANS modules and assessment tools exist, including:

o *Early Childhood*	o *Juvenile Justice*	o *Developmentally Disabled*
o *Adult Mental Health.*	o *Child Welfare*	o *Sexually Reactive*
o *Crisis Assessment*	o *Fire Setting*	o *Sexual Offending*

- Dr. Lyons will personally provide culturally sensitive customization for Native American tribes.
- Application software and statewide training and certification process are web-based.
- Benefits of implementation are estimated to begin by July 2012.

NEXT STEPS

Bureau staff will begin in December 2011 on the following work plan items:

❖ Establishing stakeholder workgroups, including providers, family members, other state child serving agencies and Bureau staff.
❖ Procurement of web-based CANS application, including web-based training and data collection system, including the following implementation considerations:
   - Ensuring HIPAA compliance throughout
   - Identifying qualifications needed for administration of the assessment, in what settings, and how frequently.
   - Planning training: How is training typically acquired and what does it cost?
   - Determining how the results of the assessment are reported, stored, communicated, compiled and tracked.
   - Determining how the tool can be used to track or measure improved functioning of the group of youth served: i.e. per provider, per agency, per service type or setting.
   - Identifying how the tool can be used to assess service gaps in the system and to report outcomes to providers, decision-makers and other stakeholders.
   - Discussing how results of the assessment are used, for which populations, and with what results?
   - Determining reimbursement method(s) for providing assessment.
   - Determining what information will be shared with the public.
   - Developing our training and payment structure for securing outcome measures at the individual levels.

CONTACT INFORMATION

If you are interested in being part of a workgroup to address the work plan items, or if you would like to receive periodic updates as they become available, please contact Dan Carlson-Thompson from the Children's Mental Health Bureau by e-mail at dcarlson-thompson@mt.gov or by phone at (406) 444-3819.

INTRODUCTION

The **CANS** is a multiple purpose information integration tool that is designed to be the output of an assessment process. The purpose of the **CANS** is to accurately represent the shared vision of the child/youth serving system—children, youth, and families. As such, completion of the **CANS** is accomplished in order to allow for the effective communication of this shared vision for use at all levels of the system. Since its primary purpose is communication, the **CANS** is designed based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding the **CANS**.

Six Key Principles of the CANS

1. Items were selected because they are each relevant to service/treatment planning. An item exists because it might lead you down a different pathway in terms of planning actions.

2. Each item uses a 4-level rating system. Those levels are designed to translate immediately into action levels. Different action levels exist for needs and strengths. For a description of these action levels please see below.

3. Rating should describe the child/youth, not the child/youth in services. If an intervention is present that is masking a need but must stay in place, this should be factored into the rating consideration and would result in a rating of an "actionable" need (i.e. "2" or "3").

4. Culture and development should be considered prior to establishing the action levels. Cultural sensitivity involves considering whether cultural factors are influencing the expression of needs and strengths. Ratings should be completed considering the child/youth's developmental and/or chronological age depending on the item. In other words, anger control is not relevant for a very young child/youth but would be for an older child/youth or child/youth regardless of developmental age. Alternatively, school achievement should be considered within the framework of expectations based on the child/youth's developmental age.

5. The ratings are generally "agnostic as to etiology". In other words this is a descriptive tool; it is about the "what" not the "why". Only one item, Adjustment to Trauma, has any cause-effect judgments.

6. A 30-day window is used for ratings in order to make sure assessments stay "fresh" and relevant to the child/youth's present circumstances. However, the action levels can be used to over-ride the 30-day rating period.

Action Levels for "Need" Items

0 – No Evidence of Need – This rating indicates that there is no reason to believe that a particular need exists. Based on current assessment information there is no reason to assume this is a need. For example, "does Johnny smoke weed?" He says he doesn't, his mother says he doesn't, no one else has expressed any concern – does this mean Johnny is not smoking weed? NO, but we have no reason to believe that he does and we would certainly not refer him to programming for substance related problems.

1 - Watchful Waiting/Prevention – This level of rating indicates that you need to keep an eye on this area or think about putting in place some preventive actions to make sure things do not get

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) — COMPREHENSIVE– 5+

Please √ appropriate use: ☐ Initial ☐ Reassessment   Date: ☐ M M / D D / Y Y
☐ Transition/Discharge

m m / d d / y y   ☐M ☐F _____
Child's Name   **DOB**   **Gender**   **Race/Ethnicity**

Current Living Situation: _____

Assessor (Print Name): _____   **Signature**
Caregiver Name: _____   **Relation**

LIFE DOMAIN FUNCTIONING

0 = no evidence of problems   1 = history, mild
2 = moderate   3 = severe

	NA	0	1	2	3
Family		O	O	O	O
Living Situation		O	O	O	O
Recreational		O	O	O	O
Job Functioning		O	O	O	
Developmental[1]		O	O	O	O
Legal		O	O	O	O
Medical		O	O	O	O
Physical		O	O	O	O
Sexuality		O	O	O	O
Sleep		O	O	O	O
School Behavior		O	O	O	O
School Achievement		O	O	O	O
School Attendance		O	O	O	O

YOUTH STRENGTHS

0 = centerpiece   1 = useful
2 = identified   3 = not yet identified

	NA	0	1	2	3
Family		O	O	O	O
Interpersonal		O	O	O	O
Optimism		O	O	O	O
Educational		O	O	O	O
Vocational		O	O	O	O
Talents / Interests		O	O	O	O
Spiritual / Religious		O	O	O	O
Community Life		O	O	O	O
Relation Permanence		O	O	O	O
Resiliency		O	O	O	O
Resourcefulness		O	O	O	O

ACCULTURATION

0 = no evidence   1 = minimal needs
2 = moderate needs   3 = severe needs

		0	1	2	3
Language		O	O	O	O
Identity		O	O	O	O
Ritual		O	O	O	O
Cultural Stress		O	O	O	O

MODULES   See Back for Module Scoring
[1] go to DD Module
[2] go to Trauma Module
[3] go to SUD Module
[4] go to Violence Module
[5] go to SAB Module
[6] go to Runaway Module
[7] go to JJ Module
[8] go to FS Module

CAREGIVER STRENGTHS & NEEDS

O Not applicable – no caregiver identified

0 = no evidence   1 = minimal needs
2 = moderate needs   3 = severe needs

	NA	0	1	2	3
Supervision		O	O	O	O
Involvement		O	O	O	O
Knowledge		O	O	O	O
Organization		O	O	O	O
Social Resources		O	O	O	O
Residential Stability		O	O	O	O
Physical		O	O	O	O
Mental Health		O	O	O	O
Substance Abuse		O	O	O	O
Developmental		O	O	O	O
Safety		O	O	O	O

YOUTH BEHAVIORAL / EMOTIONAL NEEDS

0 = no evidence
1 = history or sub-threshold, watch/prevent
2 = causing problems, consistent with diagnosable disorder
3 = causing severe/dangerous problems

	NA	0	1	2	3
Psychosis		O	O	O	O
Impulse / Hyper		O	O	O	O
Depression		O	O	O	O
Anxiety		O	O	O	O
Oppositional		O	O	O	O
Conduct		O	O	O	O
Adjustment to Trauma[2]		O	O	O	O
Anger Control		O	O	O	O
Substance Use[3]		O	O	O	O

YOUTH RISK BEHAVIORS

0 = no evidence   1 = history, watch/prevent
2 = recent, act   3 = acute, act immediately

		0	1	2	3
Suicide Risk		O	O	O	O
Self Mutilation		O	O	O	O
Other Self Harm		O	O	O	O
Danger to Others[4]		O	O	O	O
Sexual Aggression[5]		O	O	O	O
Runaway[7]		O	O	O	O
Delinquency[6]		O	O	O	O
Fire Setting[7]		O	O	O	O
Social Behavior		O	O	O	O

MODULES

NAME: _____

Date _____

DEVELOPMENTAL NEEDS (DD)

	0	1	2	3
Cognitive	O	O	O	O
Developmental	O	O	O	O
Communication	O	O	O	O
Self Care / Daily Living	O	O	O	O

SUBSTANCE USE (SUD)

	0	1	2	3
Severity of Use	O	O	O	O
Duration of Use	O	O	O	O
Stage of Recovery	O	O	O	O
Peer Influences	O	O	O	O
Parental Influences	O	O	O	O
Environmental Influences	O	O	O	O

TRAUMA (Characteristics of the trauma experience)

	0	1	2	3
Sexual Abuse*	O	O	O	O
Physical Abuse	O	O	O	O
Emotional Abuse	O	O	O	O
Medical Trauma	O	O	O	O
Natural Disaster	O	O	O	O
Witness to Family Violence	O	O	O	O
Witness to Community Violence	O	O	O	O
Witness/Victim - Criminal Acts	O	O	O	O
Other:				

*If Sexual Abuse >0, complete the following:

Emotional closeness to perpetrator	O	O	O	O
Frequency	O	O	O	O
Duration	O	O	O	O
Force	O	O	O	O
Reaction to Disclosure	O	O	O	O

Adjustment	0	1	2	3
Affect Regulation	O	O	O	O
Intrusions	O	O	O	O
Attachment	O	O	O	O
Dissociation	O	O	O	O

VIOLENCE MODULE

Historical Risk Factors	0	1	2	3
History of Physical Abuse	O	O	O	O
History of Violence	O	O	O	O
Witness to Domestic Violence	O	O	O	O
Witness Environmental Violence	O	O	O	O

Emotional/Behavioral Risks	0	1	2	3
Frustration Management	O	O	O	O
Hostility	O	O	O	O
Paranoid Thinking	O	O	O	O
Secondary gains from anger	O	O	O	O
Violent Thinking	O	O	O	O

Resiliency Factors	0	1	2	3
Aware of violence potential	O	O	O	O
Response to Consequences	O	O	O	O
Commitment to Self-Control	O	O	O	O
Treatment Involvement	O	O	O	O

SAB – SEXUALLY AGGRESSIVE BEHAVIOR

	0	1	2	3
Relationship	O	O	O	O
Physical Force/Threat	O	O	O	O
Planning	O	O	O	O
Age Differential	O	O	O	O
Type of Sex Act	O	O	O	O
Response to Accusation	O	O	O	O
Temporal Consistency	O	O	O	O
History of Sexual Behavior	O	O	O	O
Severity of Sexual Abuse	O	O	O	O
Prior Treatment	O	O	O	O

RUNAWAY

	0	1	2	3
Frequency of Running	O	O	O	O
Consistency of Destination	O	O	O	O
Planning	O	O	O	O
Safety of Destination	O	O	O	O
Involvement in Illegal Acts	O	O	O	O
Likelihood of Return on Own	O	O	O	O
Involvement of Others	O	O	O	O
Realistic Expectations	O	O	O	O

JJ – JUVENILE JUSTICE

	0	1	2	3
Seriousness	O	O	O	O
History	O	O	O	O
Arrests	O	O	O	O
Planning	O	O	O	O
Community Safety	O	O	O	O
Legal Compliance	O	O	O	O
Peer Influences	O	O	O	O
Parental Influences	O	O	O	O
Environmental Influences	O	O	O	O

FS – FIRE SETTING

	0	1	2	3
Seriousness	O	O	O	O
History	O	O	O	O
Planning	O	O	O	O
Use of Accelerants	O	O	O	O
Intention to Harm	O	O	O	O
Community Safety	O	O	O	O
Response to Accusation	O	O	O	O
Remorse	O	O	O	O
Likelihood of Future Fires	O	O	O	O

Check	RESIDENTIAL STABILITY *Please rate the highest level from the past 30 days*
0	Caregiver has stable housing for the foreseeable future.
1	Caregiver has relatively stable housing but either has moved in the past three months or there are indications of housing problems that might force them to move in the next three months.
2	Caregiver has moved multiple times in the past year. Housing is unstable.
3	Caregiver has experienced periods of homelessness in the past six months.

Check	PHYSICAL *Please rate the highest level from the past 30 days*
0	Caregiver is generally healthy.
1	Caregiver is in recovery from medical/physical problems.
2	Caregiver has medical/physical problems that interfere with their capacity to parent.
3	Caregiver has medical/physical problems that make it impossible for them to parent at this time.

Check	MENTAL HEALTH *Please rate the highest level from the past 30 days*
0	Caregiver has no mental health needs.
1	Caregiver is in recovery from mental health difficulties.
2	Caregiver has some mental health difficulties that interfere with their capacity to parent.
3	Caregiver has mental health use difficulties that make it impossible for them to parent at this time.

Check	SUBSTANCE USE *Please rate the highest level from the past 30 days*
0	Caregiver has no substance use needs.
1	Caregiver is in recovery from substance use difficulties.
2	Caregiver has some substance use difficulties that interfere with their capacity to parent.
3	Caregiver has substance use difficulties that make it impossible for them to parent at this time.

Check	DEVELOPMENTAL *Please rate the highest level from the past 30 days*
0	Caregiver has no developmental needs.
1	Caregiver has developmental challenges but they do not currently interfere with parenting.
2	Caregiver has developmental challenges that interfere with their capacity to parent.
3	Caregiver has severe developmental challenges that make it impossible for them to parent at this time.

Check	SAFETY *Please rate the highest level from the past 30 days*
0	Household is safe and secure. Child is at no risk from others.
1	Household is safe but concerns exist about the safety of the child due to history or others in the neighborhood who might be abusive.
2	Child is in some danger from one or more individuals with access to the household.
3	Child is in immediate danger from one or more individuals with unsupervised access.

*All referrants are legally required to report suspected child abuse or neglect.**

CHILD BEHAVIORAL/EMOTIONAL NEEDS

Check	PSYCHOSIS *Please rate based on the past 30 days*
0	No evidence
1	History or suspicion of hallucinations, delusions or bizarre behavior that might be associated with some form of psychotic disorder.
2	Clear evidence of hallucinations, delusions or bizarre behavior that might be associated with some form of psychotic disorder.
3	Clear evidence of dangerous hallucinations, delusions, or bizarre behavior that might be associated with some form of psychotic disorder which places the child or others at risk of physical harm.

Check	IMPULSIVITY/HYPERACTIVITY *Please rate based on the past 30 days*
0	No evidence
1	Some problems with impulsive, distractible or hyperactive behavior that places the child at risk of future functioning difficulties.
2	Clear evidence of problems with impulsive, distractible, or hyperactive behavior that interferes with the child's ability to function in at least one life domain.
3	Clear evidence of a dangerous level of impulsive behavior that can place the child at risk of physical harm.

Check	DEPRESSION *Please rate based on the past 30 days*
0	No evidence
1	History or suspicion of depression or mild to moderate depression associated with a recent negative life event with minimal impact on life domain functioning.
2	Clear evidence of depression associated with either depressed mood or significant irritability. Depression has interfered significantly in child's ability to function in at least one life domain.
3	Clear evidence of disabling level of depression that makes it virtually impossible for the child to function in any life domain.

Check	ANXIETY *Please rate based on the past 30 days*
0	No evidence
1	History or suspicion of anxiety problems or mild to moderate anxiety associated with a recent negative life event.
2	Clear evidence of anxiety associated with either anxious mood or significant fearfulness. Anxiety has interfered significantly in child's ability to function in at least one life domain.
3	Clear evidence of debilitating level of anxiety that makes it virtually impossible for the child to function in any life domain.

Check	OPPOSITIONAL *Please rate based on the past 30 days*
0	No evidence
1	History or recent onset (past 6 weeks) of defiance towards authority figures.
2	Clear evidence of oppositional and/or defiant behavior towards authority figures, which is currently interfering with the child's functioning in at least one life domain. Behavior causes emotional harm to others.
3	Clear evidence of a dangerous level of oppositional behavior involving the threat of physical harm to others.

Check	CONDUCT *Please rate the highest level from the past 30 days*
0	No evidence
1	History or suspicion of problems associated with antisocial behavior including but not limited to lying, stealing, manipulating others, sexual aggression, violence towards people, property or animals.
2	Clear evidence of antisocial behavior including but not limited to lying, stealing, manipulating others, sexual aggression, violence towards people, property, or animals.
3	Evidence of a severe level of conduct problems as described above that places the child or community at significant risk of physical harm due to these behaviors.

Check	ADJUSTMENT TO TRAUMA *Please rate based on the past 30 days*
0	No evidence
1	History or suspicion of problems associated with traumatic life event/s.
2	Clear evidence of adjustment problems associated with traumatic life event/s. Adjustment is interfering with child's functioning in at least one life domain.
3	Clear evidence of symptoms of Post Traumatic Stress Disorder, which may include flashbacks, nightmares, significant anxiety, and intrusive thoughts of trauma experience.

Check	ANGER CONTROL *Please rate based on the past 30 days*
0	No evidence of any significant anger control problems.
1	Some problems with controlling anger. Child may sometimes become verbally aggressive when frustrated. Peers and family may be aware of and may attempt to avoid stimulating angry outbursts.
2	Moderate anger control problems. Child's temper has gotten him/her in significant trouble with peers, family and/or school. Anger may be associated with physical violence. Others are likely quite aware of anger potential.
3	Severe anger control problems. Child's temper is likely associated with frequent fighting that is often physical. Others likely fear him/her.

Check	SUBSTANCE USE *Please rate the highest level from the past 30 days*
0	No evidence
1	History or suspicion of substance use.
2	Clear evidence of substance abuse that interferes with functioning in any life domain.
3	Child requires detoxification OR is addicted to alcohol and/or drugs. Include here a child/youth who is intoxicated at the time of the assessment (i.e., currently under the influence).

CHILD RISK BEHAVIORS

Check	SUICIDE RISK *Please rate the highest level from the past 30 days*
0	No evidence
1	History but no recent ideation or gesture.
2	Recent ideation or gesture but not in past 24 hours.
3	Current ideation and intent OR command hallucinations that involve self-harm.

Check	SELF-MUTILATION *Please rate the highest level from the past 30 days*
0	No evidence
1	History of self-mutilation.
2	Engaged in self mutilation that does not require medical attention.
3	Engaged in self mutilation that requires medical attention.

Check	OTHER SELF HARM *Please rate the highest level from the past 30 days*
0	No evidence of behaviors other than suicide or self-mutilation that place the child at risk of physical harm.
1	History of behavior other than suicide or self-mutilation that places child at risk of physical harm. This includes reckless and risk-taking behavior that may endanger the child.
2	Engaged in behavior other than suicide or self-mutilation that places him/her in danger of physical harm. This includes reckless behavior or intentional risk-taking behavior.
3	Engaged in behavior other than suicide or self-mutilation that places him/her at immediate risk of death. This includes reckless behavior or intentional risk-taking behavior.

Check	DANGER TO OTHERS *Please rate the highest level from the past 30 days*
0	No evidence
1	History of homicidal ideation, physically harmful aggression or fire setting that has put self or others in danger of harm.
2	Recent homicidal ideation, physically harmful aggression, or dangerous fire setting but not in past 24 hours.
3	Acute homicidal ideation with a plan or physically harmful aggression OR command hallucinations that involve the harm of others. Or, child set a fire that placed others at significant risk of harm.

The Child and Adolescent Needs and Strengths (CANS) Customization workgroup held a kickoff meeting on Tuesday April 17, facilitated by Dr. Martha Henry, who led the statewide CANS implementation and training for 10,000 users in Massachusetts four years ago. Some preliminary decisions were made at this meeting, and a CANS Policy Subcommittee was formed to address policy issues and provide recommendations to the larger CANS Customization Workgroup. Below is a summary of the meeting and an outline of the work ahead.

CANS Administration: The purpose of the CANS is to accurately represent the shared vision of the youth and family to the child-serving system by assessing the needs, strengths, and resources of the youth and family. The CANS is completed by a certified CANS team member.

CANS Target Populations: Ages 0 to 21
Youth with Serious Emotional Disturbance (SED)
Youth who receive intensive Medicaid funded mental health services

Initial Uses of the CANS:
1. To assist the youth and family team in developing an individualized treatment plan based on the needs and strengths of that family;
2. To communicate youth and family needs and strengths to new treatment team members or new service providers when the youth transitions to new services (admission/discharge);
3. To display changes in the youth's and family's needs and strengths as an individualized measure of outcome of treatment over time; and
4. To aggregate data about the outcome of treatment for specific populations, for example, sorted by service type, individual provider, and geographical region.

Guiding Principles for CANS Customization:
1. Address the "what", not the "why" of the youth's circumstances;
2. Avoid duplication and redundancy of items;
3. Only include items that affect service planning;
4. If different versions are developed, the importance of keeping items consistent for continuity;
5. Must be used with team to inform treatment planning and avoid single person completing form; and
6. Use the least number of items possible to identify needs and strengths that lead to excellent treatment planning.

ISSUES ASSIGNED TO CANS POLICY SUBCOMMITTEE

1. Policy issues around administration
1. Who is responsible for administering the CANS?
2. What are the qualifications of the person responsible?
3. What are the responsibilities of the other members of the team relative to the CANS?
4. When is the CANS required? (i.e. before admission to the services, upon admission, prior to discharge)
5. How frequently (at what interval and under what circumstances) is the CANS administered?
6. How much time does a provider have to complete the CANS and submit the results?
7. How are the results submitted and to whom?
8. How is it handled when an item is not scored?
9. HIPAA considerations, including confidentiality, access to data and data sharing

2. Design Preference for CANS Customization:
The issue is the use of domains with items vs. additional modules to capture specific information that does not apply to the whole population. Below are some existing modules that the subcommittee will consider and make recommendations regarding implementation as domain (a required series of questions) or module (optional, to be administered at the discretion of the provider):

1. Early Childhood	5. Substance Use	8. Juvenile Justice	11. Developmental Disabilities
2. Transition Age	6. Suicide	9. Adult Mental Health	12. Sexually Reactive
3. Trauma	7. PRTF	10. Autism Spectrum	13. Sexual Offending
4. Abuse / Neglect			